TO: Jack Lew
FROM: Jennifer Klein
DATE: 5/11/94

Benefit Savings Options for Energy and Commerce

- $1,500/3,000 to $2,500/3,000 and $250 per hospital admission and $10 prescription drug copayment in lower cost sharing = 5% reduction in premium.

Additional Benefit Savings Options

- Prescription drug changes
  - .2 to .4 in higher cost sharing and $10 to $13 in lower cost sharing = 1% reduction in premium.
  - .2 to .4 in higher cost sharing and leave $10 in lower cost sharing = .5% reduction in premium.
  - .2 to .6 in higher cost sharing and $10 to $16 in lower cost sharing = 2% reduction. Raising coinsurance to .5 in higher cost sharing is not sufficient.

  NOTE: These reductions may be added to the 5% reduction being considered by Energy and Commerce.

  BUT: We are continuing to look at the impact of these changes on cost sharing subsidies.

  Changing HMO cost sharing to coinsurance has no useful effect. A $5 copayment is roughly equivalent to 20% coinsurance and a $10 copayment is roughly equivalent to 40% coinsurance.

- Dental changes

  Eliminate dental for children and cover Medicaid-eligible children or children under 150% of poverty in Medicaid wrap-around program = 2% reduction.

  NOTE: These reductions may be added to the 5% reduction being considered by Energy and Commerce.

  BUT: This will increase federal costs as more people are shifted into the wrap-around program.

- Lower cost sharing changes

A $250 per admission deductible is comparable to a $60 per day copayment without a limit on the number of days it will be paid or a $75 per day copayment with a limit of 10 days (i.e., if hospital stay is longer than 10 days patient stops paying per day copayment).

Benefit Change Options for Premium Reductions

1. 5% reduction

   a. Raise coinsurance from .2 to .25
   b. Raise cost-sharing maximum from $1,500 per person to $2,500
   c. Raise deductible from $200 per person to $325.

2. 10% reduction

   a. Raise coinsurance maximum to $2,000, raise deductible to $325, and cut mental health benefit to Blue Cross Standard Option level.
   b. Raise coinsurance maximum to $2,000, raise deductible to $325, and eliminate special preventive services package.
   c. Eliminate prescription drug coverage.
   d. Eliminate mental health coverage.

3. 20% reduction

   a. Raise coinsurance maximum to $2,000, raise deductible to $300, eliminate mental health coverage, and eliminate special preventive services package.

   b. Raise coinsurance maximum to $2,000, raise deductible to $325, eliminate prescription drug coverage, and eliminate special preventive services package.

4. 30% reduction

   a. Raise coinsurance maximum to $2,000, raise coinsurance rate to .25, eliminate mental health coverage, eliminate prescription drug coverage, and eliminate special preventive services package.

   b. Raise coinsurance maximum to $2,000, raise coinsurance rate to .25, raise deductible to $325, eliminate mental health coverage, and eliminate prescription drug coverage.

PRELIMINARY DRAFT
May 16, 1994 (10:51am)

GENERAL DESCRIPTION	**Benefit Package:** · To reduce the costs of the mandate to employers in the first few years, two benefit packages, a basic package and a standard package, would be defined. The basic package would be [20%] less than the standard package. Employer payment requirements would be based on the basic package. · Over a 5-year period, if federal saving are achieved, the value of the basic package would be phased-up to the value of the standard package. ▸ Savings would be assessed annually before benefits are expanded. **Firms with more than 20 employees:** · Employers would be required to pay 80% of the average premium for the basic benefit package. · Employers payments would be capped at a specified percentage of each worker's wage. Smaller firms would receive more generous subsidies. · All firms would be eligible for subsidies. **Firms with 20 or fewer employees ("exempt employers"):** · Exempt employers would not be required to provide coverage. · Exempt employers with fewer than 10 workers pay 1% of payroll. · Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers pay 80% of the average premium for the basic package and are eligible for subsidies. · The exemption would be eliminated if 90% of currently uninsured workers are not insured by 1998 and 95% insured by 2000. **Tax treatment:** – Tax treatment of employer contributions is the same as in the HSA. **Maintenance of Effort:** OPTION, require employers that currently contribute more than the cost of the basic package to maintain effort (modelling should assume MOE).

GENERAL DESCRIPTION (Continued).	**Families:** · Families working for nonexempt employers pay the difference between the 80% of the average premium for the basic package and the premium of the plan they choose. · Families working for exempt employers pay the entire premium. · Families choosing the standard package are responsible for the full difference between the two packages. · Low-income families are capped at a percentage of income for the family share for the basic package. · Families working for exempt employers are capped at percentage of income for the entire premium for the basic package. · Special subsidies toward cost-sharing are provided for low-income families during the phase-in period. **Cost Containment:** · Reverse trigger approach. **Subsidies:** · Federal subsidy costs are capped as in HSA **Community Rating:** · The threshold for community rating is reduced to firms with 1000 or fewer employees. · Firms above the threshold would pay a payroll surcharge of 1%.

DETAILED SPECIFICATIONS	
. Structure	· Each health plan would offer two benefit packages, a basic package and a standard package. · Employers would be required to pay 80% of the average premium for the basic benefit package. Employers could pay more (toward the standard package or for supplemental benefits). · Families would be required to have at least the basic package. · All families, including families working for exempt employers, could choose either package. Families would pay the difference between the basic and standard package (without subsidies, although employers may contribute).
. Benefit package; phase-in	Two benefit packages, a standard package and a basic package. Basic package phases-up to standard package over five years. Standard package: · HSA benefit package (with 5% reduction). ▸ FFS and HMO packages as in HSA, with 5% reduction as in Energy and Commerce Staff Draft. Basic package (still under development): · [20%][1] lower value than standard package. ▸ FFS package with higher (e.g., $1500 - $2000) hospital deducible and higher (e.g., 25%) coinsurance; reduce value of other benefits through higher cost sharing or limits. Preserve preventive care (either with minor copayments or put in the wrap package for children). ▸ HMO package would closely resemble FFS package, with copayments rather than coinsurance. · Federal deficit reduction targets would be incorporated into law. Annual reviews would be conducted to determine if targets met. Benefit expansion would occur only if deficit reduction target is met. ▸ Deficit reduction target would be $50-100 B over ten years (assume lower targets in early years).
	Issues: · With two different levels of benefits, adverse selection against the standard benefit package is a danger. Risk adjustment across the packages could increase the cost of the basic package (Jim is working on this).

[1] Three scenarios should be tested, with the value of the basic package 10%, 15% and 20% less than the standard package.

. Employer Payments	Firms with more than 20 employees: · Employers generally would be required to pay 80% of the average per worker premium for the basic benefit package. ▸ Employer payment for each worker would be capped at the lower of 80% of the average per worker premium or a specified percentage of the worker's wages (Scenario A schedule). ▸ Large firms (over 1000 threshold) would be eligible for subsidies based on the average per worker premium for community- rated employers in the area. Exempt firms: · Exempt employers would not be required to provide coverage. ▸ Exempt employers with fewer than 10 workers pay 1% of payroll. ▸ Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers are treated as above. · The exemption would be eliminated if specified percentages of the population are not covered by specified dates: ▸ 90% of currently uninsured working families must be insured by 1998; ▸ 95% of currently uninsured working families must be insured by 2000. Self-employed people: · OPTION 1. Self-employed people with employees are treated as employees of themselves and are eligible for exemption. Self-employed people without employees pay as under the HSA (e.g., self-employed with working spouses make payments that are applied to reduce federal subsidies). · OPTION 2. All self-employed people are eligible for exemption.

. Employer Payments (Continued)	Per worker premiums: The per worker premium calculation would be based on the employer contributions for the basic package; employer contributions above the amount required (including any payment toward the difference between the basic package and the standard package) would be considered to offset family payment responsibility. Firms with fewer than 20 employee that choose to provide coverage are counted in per worker premium calculation.
. Family Payments	Families working for nonexempt firms (including exempt firms that choose to provide coverage): · Families pay 20% of the average premium for the basic package. · Low-income families are capped at a percentage of income for the family share for the basic package. (Scenario A subsidies). Families working for exempt employers: · Families working for exempt employers pay the entire premium (a per worker employer share and a family share) for the basic package. · Families working for exempt employers are capped at a percentage of income for the entire premium. ▸ The cap ranges from 4-6% (Kennedy schedule for exempt workers). Nonworking families: · Nonworkers pay toward the employer share as under Scenario A. Families choosing standard package: · Families choosing the standard package are responsible for the full difference between the basic and standard packages. · No subsidies apply to the difference. Special rules for dual earners: · Families with a worker in an exempt firm and a worker in a nonexempt firm are treated as a family working for a nonexempt firm.

. Subsidies	Federal costs for subsidies are capped as under the HSA. Employers: · Employer payments for an employee for the basic plan are capped at 2.8% to 12% of the employee's wages. (The Scenario A subsidy schedule applies.) · Caps apply to all employers. For experience rated employer, payments are subsidized only up to the level of required employer contributions for the basic plan in the appropriate community rating area. Families: · Family payments for the family share of the basic plan are capped at 3.9% of income. (The Scenario A subsidy schedule applies.) · Families working for exempt employers are capped at 4-6% of income for the entire premium obligation (Kennedy schedule for exempt workers). · Payments for nonworking families for the employer share are based on nonwage income and are capped as under the Scenario A approach. · Special subsidies for cost-sharing are provided for low-income families during the benefit phase-in period. ‣ Low income families enroll in HMOs (if available). For those under poverty, the difference between the standard HMO cost-sharing and the basic HMO cost-sharing is fully subsidized. For those with incomes below 150% [200%?] of poverrty a portion of the difference would be subsidized (on a sliding scale basis). ‣ If no HMO is available, low-income families would be subsidized to the same extent in a non-HMO plan. Self-employed: · OPTION 1. Self-employed people without employees pay as under Scenario A (e.g., self-employed without employees capped at small employer schedule). · OPTION 2. All self-employed people are treated as exempt workers unless they employ more than 20 workers in their firm.

. Community rating threshold	Firms with 1000 or fewer employees are part of community rated pools. · Large firms cannot elect to be community rated. · Taft-Hartley trusts and rural electric and telephone cooperatives can elect to be experience rated. · State and local governments are community-rated employers. · All experience rated employers (including state and local governments) pay a 1% of payroll surcharge.
. Cost containment	· Constrain initial premiums (as under HSA) and growth rates as follows: ▸ OPTION 1. HSA growth rates. ▸ OPTION 2. Managed competition growth rates through 1998, HSA growth rates thereafter.

Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, Virginia 22003

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(703) 941-7400
FAX (703) 941-3951

Date: 26 May 94

----------*Please Deliver Immediately*----------

To: Jennifer Klein

From: Jim Mays

Re:

Memo: HSA minus 5 minus 10, 15, 20%

Garden is working on HMO's - 20% more may not be practical in a reasonable manner.

We are transmitting 2 pages (including this transmittal sheet).

MEMORANDUM

To : Jennifer Klein

From : Jim Mays

Subject : More Cost-sharing Variations - (Fee-for-service only)

Copy : Ken Thorpe

Following up on your request for options to cut 10%, 15%, and 20% off the "HSA-5%" level, here are cost-sharing changes which should generate approximately these additional savings.

Additional 10% cut:

deductible = $500/$1,000
coinsurance = 25%
cost-sharing maximum = $2,500/$3,000

Additional 15% cut:

deductible = $700/$1,400
coinsurance = 25%
cost-sharing maximum = $3,000/$3,000

Additional 20% cut:

deductible = $1000/$2,000
coinsurance = 25%
cost-sharing maximum = $3,000/$3,000

ccsol
/a /s

NOTE TO: Len Nichols, Jennifer Klein, Chris Jennings 5/25/94

From: Ken Thorpe

Subject: Options For 15% Reductions in FFS Off of a HSA Base

Attached is a copy of a table showing option packages for achieving a 15% reduction in fee-for-service. The base used for the reductions was HSA.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ► 1

To Jennifer Klein	From Ken Thorpe
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

5/25/94

TABLE 1
OPTION PACKAGES FOR 15% REDUCTIONS (HSA BASE)
FOR FEE-FOR-SERVICE*

Option I

Raise Cost Sharing .20 to .25
Raise Out of Pocket $1500 to $2500
Raise deductible to $400
Add a $250 per hospital admission deductible

Option II

Raise Cost Sharing .20 to .25
Raise Out of Pocket $1500 to $3000
Cut Mental Health benefit to Blue Cross Standard
Change Prescription Drug cost sharing (.2 to .6 in higher)

Option III

Raise Out of Pocket $1500 to $2500
Eliminate Prescription Drug or Mental Health

Option IV

Raise Out of Pocket $1500 to $2,000
Raise deductible to $250
Eliminate preventive services package
Cut mental health benefit to Blue Cross Standard

*To get full 15% will need comparable reductions in HMO benefits. HMO package options under development to be provided.

Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, Virginia 22003

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(703) 941-7400
FAX (703) 941-3951

Date: 5/27/94

---------- *Please Deliver Immediately* ----------

To: Jennifer Klein

From: Gordon Trapnell

Re:

Memo: These are still in draft form. I still need to finalize the numbers

We are transmitting 2 pages (including this transmittal sheet).

Table 1

Alternative Cost Sharing to Reduce Premiums for "Low" Cost Sharing Plans

(All copayments assumed to be indexed from 1994 to applicable year by increase in premium rates)

Item	H.R. 3600	Save 10%	Save 15%	Save 20%	Save 25%
Admissions to hospitals or specialized facilities	0	250	250	250	500
Copayment per day of hospital confinement	0	0	25	50	100
Copyament per day in SNF or hospice	0	0	12.5	25	50
Emergency room use (1)	$125, unless emergency	100	125	125	150
Inpatient surgery (2)					
Primary surgeon	10	100	250	500	500
Assistant surgeon (3)	0	50	100	250	250
Delivery (2)					
Normal	10	100	250	500	500
Caesarian	10	100	500	1000	1000
Non-delivery	10	25	100	250	250
Outpatient surgery (4)					
OP dept	20	100	150	250	250
Surgi-Center	20	50	75	150	150
Office	10	15	25	35	50
Outpatient hospital services	10	15	25	35	50
Preventive care					
Physical exams	0	0	25	50	100
Other	0	0	0	0	10
Physician and dental visits (5)					
Acute primary care	10	10	15	20	20
Inpatient visits (6)	0	15	20	25	35
Other specialty referrals	10	20	25	35	50
ADM residential or outpatient	25	35	50	50	50
Routine vision exams	10	20	25	35	50
Other pracititioners	10	20	25	35	50
Home health care	10	15	20	25	35
Ambulance	0	25	50	75	100
DME, prosthetics, orthotics, contraceptive devices	0	20	50	50	50
Prescriptions	5	10	15	15	20

(1) Includes physician charges

(2) In addition to hospital deductible

(3) When covered

(4) Includes facility charge

(5) Other than prevention, ADM, and vision

(6) Includes professional charges for inpatient radiology, pathology, anesthesiology, etc.

To: Jennifer Klein, Len Nichols, Jack Lew
From: Ken Thorpe
Re: Gephardt Benefit Package Change
Date: May 18, 1994

Assuming we increase the FFS overall deductible to $250 / $500, and get a 1.2% reduction, we face the following HMO options for a similar benefit reduction (again assuming we are starting at CBO - 5% already).

1. Increase emergency room co-pay from $10 to $100 if participant is not admitted.

2. Same as 1, but increase to $50 and include $100 surgical inpatient co-pay (on top of $250 per admission).

3. Increase all $10 copayments for professional services to $12.50.

4. Increase drug copayment from $10 to $13.

5. Increase hospital per admission deductible from $250 to $400.

6. Increase emergency room co-pay to $50 and increase hospital per admission deductible from $250 to $325.

To: Jennifer Klein, Len Nichols
From: Ken Thorpe
Re: Gephardt Benefit Package Change
Date: May 17, 1994

Assuming we increase the FFS overall deductible to $250 / $500, and get a 1.2% reduction, we face the following HMO option for a similar benefit reduction (again assuming we are starting at CBO - 5% already).

$15 emerg.

1. Increase emergency room co-pay from $10 ~~to $100 if participant is not admitted.~~

2. ~~Same as 1, but increase to~~ $50 and include $100 surgical inpatient co-pay (on top of $250 per admission).

3. Increase all $10 copayments for professional services to $12.50.

$10 → 11 drugs

4. Increase drug copayment from $10 to $13.

$250 → 300

5. Increase hospital per admission deductible from $250 to $400.

6. Combination

Is this right?

$50 emerg. room + ($325) per admission deductible

Post-it™ brand fax transmittal memo 7671 | # of pages ▸

To Jennifer Klein	From Jim Mays
Co.	Co.
Dept.	Phone # 703-941-7400
Fax # 202-456-2878	Fax #

QDC1

MEMORANDUM

To : Ken Thorpe

From : Jim Mays

Subject : Deductible Changes

Based on what you all said CRS was doing on cost-sharing maximum changes, our estimates of the likely scoring of deductible changes from $200 single (double for family) are:

deductible	change from HSA premium (with cost-sharing maximum already raised to $2500/$5000)
$250/$500	-1.2%
300	-2.1%
325	-2.5%

3

qdc1
/a /s

Jennifer -

Also - $250 per admission deductible should get about -2%.
On HMO, raising per admission deductible to $400 gets about -1%, $550 gets -2%.

Page me if you have any questions.

Jim

5/17 Asked Ken -- get additional 1% on HMO

1. Assumes already 5% in other ways
2. Implications for out-of-pocket subsidies
   e.g. hospital has different occurrence than prof. services

What if do dental for all under 150% of poverty?

What about cost shifts to government? Impact on cost sharing subsidies?

Cost Sharing Waivers for those Less than 200% of Poverty

	5-Year Cost (1996-2000)	10-Year Cost (1996-2004)
Less than 100% Poverty: 20% HMO Cost Sharing 100-150% of Poverty: 40% HMO Cost Sharing 150-200% of Poverty: 100% HMO Cost Sharing	40.0 b	95.7 b
Less than 100% Poverty: 20% HMO Cost Sharing	24.4 b	58.3 b
Less than 100% Poverty: 40% HMO Cost Sharing	18.3 b	43.7 b
Less than 100% Poverty: 50% HMO Cost Sharing 100-150% of Poverty: 75% HMO Cost Sharing	19.8 b	47.3 b

These costs represent the change from the Health Security Act base that includes out-of-pocket subsidies.

* Assumes starting point is HSA - 5%; with $250 hospital deductible, $10 drug co-pay.

May 10, 1994

To: Jennifer Klein, Len Nichols
From: Ken Thorpe
Re: Gephardt Benefit Package Change
Date: May 17, 1994

Assuming we increase the FFS overall deductible to $250 / $500, and get a 1.2% reduction, we face the following HMO option for a similar benefit reduction (again assuming we are starting at CBO - 5% already).

1. Increase emergency room co-pay from $10 to $100 if participant is not admitted.

2. Same as 1, but increase to $50 and include $100 surgical inpatient co-pay (on top of $250 per admission).

3. Increase all $10 copayments for professional services to $12.50.

4. Increase drug copayment from $10 to $13.

5. Increase hospital per admission deductible from $250 to $400.

6/1/94

Modelling specs for MBB2

Benefit package/premiums	5% below CBO's HSA, plus adverse selection "tax" of: 1996-98 8% 1999 (year 4) 6% 2000 (year 5) 5% 2001 (year 6) 0%
Premium caps	same as HSA, in principle, but will be impossible to get same effectiveness without universal coverage, since more $ will be outside premiums for a while. Will supply percents and growth rates through time separately.
Before universal coverage (year 5), age rating	maximum ratio 2:1. Use AHCPR breaks devised for L&HR/Finance.
6 month pre-existing condition waiting period if previously uninsured, until universal coverage	reduces adverse selection, but insignificantly (ignore).
Uncompensated care pool for interim period	Financed through community rate, should have no net effect on premium vs. CBO's HSA if premium caps in place and net average provider prices can be assumed to adjust appropriately each year as well, EXCEPT for utilization increase due to claims-based reimbursement for high risk cases. Need to add x% to premium for this.
General Individual Mandate after 5 years (nonworkers, part-timers, self-employed)	Bulk of uninsured will get coverage in year 6.
Medicaid cash	capitated as in HSA from year 1 in all states
Medicaid non-cash	capitated until individual mandate, covered from year 1 in all states

Have some subsidy for 89% share

Firms with 100+	employer mandate triggered if 85% of families in these firms who are currently uninsured are not covered after three years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 25-99	employer mandate triggered if 80% of families in these firms who are currently uninsured are not covered after four years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 1-24	employer mandate triggered if 75% of families in these firms who are currently uninsured are not covered after five years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firm subsidy schedule for firms that do offer:	2.8-12% individual wage caps, depending on firm size and average wage of firm;
Payroll assessments:	firms with ≤ 10 that don't offer pay 1% of payroll; firms with ≥ 11 that don't offer pay 2% of payroll. firms with ≥ 1000 pay ??? (hard to levy with no mandate)

Household subsidies:	HSA on 20% share; HSA schedule for non-full time workers for 80% share, counting wage and self-employed income; MAYBE: overlay 4-6% income protection for workers in exempt firms;

I. Financial highlights

- o Premium higher during interim transition to universal coverage, because:
  - Medicaid larger percentage of community rating pool
  - adverse selection until mandates complete
- o Number of premium subsidy recipients is smaller during interim transition to universal coverage, until mandates complete universal coverage.
- o Medicaid savings phased-in quicker, but given higher premiums, may require higher payments per capita than in HSA.
- o Number of uninsured determined by:

II. Risks

- o Medicaid "in" before universal coverage may increase pressure for self-insurance to avoid higher community rate.
- o May be impossible to sustain 1000+ assessment until year 4. Most financing packages need this money.
- o Uninsured problems could increase during interim.

COMPARISON OF HEALTH SECURITY ACT AND SENATE LABOR AND HUMAN RESOURCES COVERAGE AND COMPREHENSIVE BENEFITS

SERVICE / BENEFIT	KENNEDY	HSA	COMMENT
Coverage	includes additional provision to specify that children in State supervised care (defined) are considered a family of one and enrolled by the State in a FFS plan unless the State has "estabished a special health service delivery system" for children in state supervised care.		provides incentive for organizing coordinated systems for kids in foster care, etc...
COST SHARING			
- lifetime limit	- none	- none	
- oop maximum	- $2,500/$3,000	- $1,500 / $3,000	
- services contributing to OOP	- all contribute	- not all MI/SA services (INR) contribute	
- deductible	- $250 / inpatient hospitalization (lower) - $200/$400 (higher)	- none (lower) - $200/$400 (higher)	
- drug deductible	- same	- $250 (higher)	
- non preventive dental	- same	- $ 50 (higher)	
- co insurance	- $10 copay on physicians and drugs (lower); 20% (higher)	- $10 copay on physicians & $5 on drugs (lower); 20% (higher)	
- Point of Service coinsurance	- specifies that out of network clinical preventive services will have cost-sharing imposed	- silent - clinical preventive services would have no cost sharing regardless of site	preserves ability of managed care plans to keep patients in-network for preventive services

SERVICES	KENNEDY	HSA	COMMENT
REDUCTIONS IN COST SHARING FOR LOW INCOME	- 20% of normal copay for families on AFDC, SSI enrolled in lower cost sharing plans expanded to all families below 100% poverty & to families between 100-150% of poverty (who are not on AFDC/SSI) who are in community rated health plans. - 40% of normal copay for families between 150-200% of poverty who are in community rated plans, regardless of whether is lower cost sharing plan - same reductions for families under 150% in areas with no lower cost sharing plan.	- 20% of normal copay for AFDC and SSI - reductions down to level of lower cost sharing plan for families at less than 150% who live in areas with no lower cost sharing plans available.	- this particular feature may be a drafting glitch as should be for those in lower c/s plans
HOSPITAL SERVICES	same as HSA	unlimited days cost sharing depending on plan	
HEALTH PROFESSIONALS	- same as HSA, except for additional provisions under MI/SA section which specifies that the restrictions in 1861(e) of the SSA - requiring physician admittance to hospital - do not apply when individuals are under the care of a mental health or substance abuse professional in a State in which such care is permitted by law.	Services that are lawfully provided by a physician,or those services provided by another person who is lawfully authorized to provide those services.	eliminates possible restrictions from Medicare that we also do not want
	- same override language	- override of restrictive state practice laws	

SERVICES	KENNEDY	HSA	COMMENT
HEALTH FACILITIES	- same as HSA	Defines qualifying hospital, but otherwise relies on state licensure of facility providers.	
DURABLE MEDICAL EQUIPMENT	- clarifies language and expands coverage of prosthetics that are surgically inserted, attached to the body, or external devices. clarifies that repair and maintenance is covered for all types of DME.	DME, prosthetics, braces, artificial limbs, eyes, fitting and training.	still has DME restriction in Medicare: ie only in home use.
OUTPATIENT LABORATORY, RADIOLOGY, DIAGNOSTIC SERVICES	- itemizes that genetic testing and counseling is covered.		
PRESCRIPTION DRUGS	- includes accessories and supplies that "are used directly with drugs and biologicals to achieve the therapeutic benefit" - includes medical foods prescribed by a physician that meet FDA requirements for inborn errors of metabolism		This covers syringes

CLINICAL PREVENTIVE SERVICES			
- clinician visits	same as HSA	specifically defined as to content	
- cost sharing	none	- none	
- well child services	0-20: total of 26 visits additional tests: 1 HCT, 1 metabolic screen, 2 UAs, and 1 TB screen for 0-3 years; 1TB screen for 3-5 years; 1 HCT and 1 UA for 6-12 years; 1 HCT, 1TB, and 1 UA for 13-19 years; additional immunizations: 1 MMR for 3-5 years;	0-20: total of 17 visits tests: 1 HCT and 2 blood leads for 0-3 years; 1 UA for 3-5 years; pap and pelvics for 13-19 years;	This appears to be the Bright Futures/AAP schedule, however in that, many of these tests are only for identified RISK groups.
- adult preventive services	same as HSA except for:	- visits every 3 yrs for 20 - 39; every 2 yrs for 40 - 64, every year for 65+ - pneumococcal, influenza vaccine	
	- mammograms every 2 years for women 40-49 years "in consultation with their physician", every year for women 50-64, and every 2 years for 65+;	- mammograms every 2 yrs for women 50+	
	- paps and pelvics annual til 3 negatives then every 3 yrs; annual for women at risk of STD's; - annual chlamydia and gonorrhea screening for women at risk from 13 to 65.	- paps and pelvics annual til 3 negatives; every 3 yrs for 20-39, every 2 yrs for 40+ - annual chlamydia and gonorrhea screening for women at risk 13 to 50.	wording on pap/pelvics is different but functionally same - not more as touted in summary & press, except for older women.

SERVICES	KENNEDY	HSA	COMMENT
PRENATAL CARE	no cost sharing	no cost sharing	
FAMILY PLANNING	no cost sharing; defined to include contraceptive drugs and devices approved by FDA	cost sharing applies; only prescribed contraceptive drugs and devices	there appears to be a drafting glitch in this section re: cost sharing
CHANGES IN CLINICAL PREVENTIVE SERVICES	NHB must identify high risk groups within 1 year of enactment	NHB, in consultation with experts in clinical preventive services, specifies additional items for high risk populations, modifies existing package but may not change cost sharing	
PREGNANCY RELATED SERVICES	all covered	all covered	
HOSPICE	- same as HSA	- unlimited for terminally ill; same covered services as Medicare.	
HOME HEALTH	- same as HSA except that is after "illness, injury, disorder, or other health condition."	- As an alternative to inpatient care after illness or injury. - Reevaluation after 60 days by the home health provider. - Deductible and cost-sharing apply in high cost plan, full coverage in low cost plan. (Note HSA would amend Medicare to require 10% coinsurance except those received within first 30 days of inpatient hospital discharge.)	

SERVICE	KENNEDY	HSA	COMMENT
EXTENDED CARE FACILITY	- essentially same as HSA except: - after illness, injury, disorder or health condition; - 100 day limit may be waived if prescribing health care professional (not provider) deems that it is "cost effective" alternative to necessary hospital services.	- Same services as Medicare. - Alternative to hospital care after illness or injury, 100 day annual limit.	
OUTPATIENT REHABILITATION SERVICES	- expanded to include respiratory therapy and audiology services; - after an illness, injury, disorder or health condition; - establishes a prevention & maintenance program which continues as long as improving or minimizing limitation.	PT, OT, ST for 60 days after illness or injury with reevaluation for improvement	The expansion of this benefit comes at little or no cost due to prevention /maintenance program

SERVICE	KENNEDY	HSA	COMMENT
MI / SA SERVICES			
coverage	- expanded to include individuals with "multiple mental disorders or mental retardation and mental illness" - expanded to include for children under 5 years "at risk of a mental disorder"		not sure of impact of this provision very broad eligibility for early childhood
definitions	- case management not limited to individuals receiving outpatient therapy and discretion of health plan health professional removed - clarification of non-physician health professionals admitting (see above under health professionals) - medications management definition includes definition of visit as one week <u>INPATIENT</u> - defined to not include residential services and has a 30 day annual limit, of which 15 days "may not be reduced in substitution for other covered services". $250 deductible per hospital inpatient admission - residential services for MI and SA are available on a 4 for 1 trade for inpatient days until 15 are left. The Secretary may increase the reduction period if "actuarilly equivalent". The limit does not apply to SA treatment in certain settings, some listed, others to be determined by the Secretary.	- case management only for outpatient treatment - medical management not defined <u>INPATIENT</u> - for both inpatient & residential, a 30 day annual limit with 30 additional days available under certain circumstances. One day deductible.	- does not define group therapy anywhere so not clear if covered clarifies coverage of methadone maintenance programs

SERVICE	KENNEDY	HSA	COMMENT
MI/SA (cont.)	INTENSIVE NON RESIDENTIAL - similar settings, etc but no day/visit limitations or trade for inpatient structure; also removes plan discretion section for this service	INR - Intensive non-residential treatment services (including partial hospitalization, day treatment, psychiatric rehabilitation, home-based services, and behavioral aide services) for first 60 days as trade against 30 day inpatient. 60 additional days under certain circumstances. 1 day deductible and 20% cost-sharing first 60, 50% on second 60 in high cost sharing. Full coverage first 60, and $25/day second 60 in low cost sharing.	These and other expansions in the benefit package are financed by the increased cost sharing schedule up front.
	OUTPATIENT - no limits and co-pay/insurance levels same as other services, even for psychotherapy	OUTPATIENT - No outpatient visit limitation. - Effective coinsurance rate of 50% on treatment (e.g.,psychotherapy, substance abuse counseling) or $25 in managed care. - All other outpatient (i.e., medication mgt, diagnosis, substance abuse counseling, crisis, somatic treatments)same as other visits (20% or $10).	

SERVICES	KENNEDY	HSA	COMMENT
MI/SA (cont.)	- 2 new provisions relating to delivery systems: 1) specifies that plans may use techniques to achieve "quality managed care" such as using behavioral managed care entities to administer benefits **if** the State has certified them as able to "facilitate the provision of clinically appropriate, cost-effective, and confidential treatment"; 2) incorporates Ed and Labor section on "special delivery requirements for services to children".		
DENTAL CARE	- same as HSA		
HEARING AIDS	- covered for children under 18 years	poor children only (wrap)	
INVESTIGATIONAL TREATMENTS	- same as HSA except specifies that the health plan may choose to cover the investigational treatment "based on objective protocols applied consistently to all enrollees".	routine care covered in approved research trials investigational treatment itself may be covered by plan for certain life threatening conditions	Kennedy approach may help to address variability in plan level decisions in this area.

SERVICES OTHER PROVISIONS	KENNEDY - defines "extra contractual services" to allow plans to provide any other item or services determined to be appropriate by the plan and the individual which are the most "cost effective way to provide appropriate treatment to the individual" - specifies that all plans shall comply with regulation or guidelines established by the NHB - amends the flexibility in delivery clause of the HSA by specifying that plan methods must be "consistent with standards of quality care and so long as the plan complies with the provisions of this Act". - adds a provision for providers to have a "duty to disclose incorrect test results" promptly after discovery of the error.	HSA	COMMENT This provision provides plans the flexibility of using individual benefit management, important to families with disabilities. This appears to be rather sweeping authority to restrict plan flexibility.
EXCLUSIONS	- same except for hearing aids		

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

TO: Jennifer Klein

FAX: 456 2599

FROM: Mary Beth

DATE AND TIME: _____

NUMBER OF PAGES: COVER + ~~2~~ 0

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May 16, 1994

TO : Senate Labor and Human Resources Committee
Attention: David Nexon and Mary Beth Fiske

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : **Varying the Benefits in the Health Security Act, S. 1757– Premium Effects**

In response to our meeting and subsequent phone conversations I have prepared the following memorandum analyzing the effect of various benefit changes on health insurance premiums.

In the first stage of this analysis we used the Health Security Act, S. 1757, as a basis for comparing any changes in the benefit package. In conjunction with our consulting actuaries at Hay/Huggins Co., Inc., we then estimated the actuarial value of the benefits changes specified in Chairman Kennedy's mark dated May 11, 1994.

With the estimates of actuarial value, I have used the Census Bureau's March 1993 Current Population Survey (CPS) to model the distribution of the U.S. population[1] into the four types of coverage groups specified in S. 1757: self only, two adults, single-parent families and two-parent families.

Table 1 details the effect of the benefit changes on the four premium types specified in S.1757. The percentage change estimates are of the total premium and have been calculated for both the high and low cost sharing plans. It is unclear how the premium estimates under the combination plan would be effected, but given the hybrid nature of the combination plan we are comfortable with the assumption that the high and low cost sharing estimates provide a reasonable range of estimates for the combination plan. No assumptions have been made about how people might sort themselves into the different plans. It is assumed that the populations covered by the high and low cost sharing plans are demographically similar to the population overall.

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[1]Except those people who primarily rely on Medicare for their health insurance.

Table 2 provides some details of our interpretation of the provisions. We have tried to put ourselves in the position of an insurer determining what benefits are covered, at what cost sharing. If in any of these provisions we have misinterpreted the intent please let us know.

There are a few areas where we are not yet able to make estimates of the effects of Chairman Kennedy's mark. Our work on the premium effects of your changes to the mental health coverage should be completed shortly.

The overall effect of the benefit changes specified in table 1 reduces premiums between 1.2 and 2.6 percent. Keep in mind, that we have only analyzed the changes specified in table 1 and other modifications could alter the overall result considerably.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or we can be of further assistance, I can be reached at 7-7347.

TABLE 1. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage

Benefit	Individual		Couple		Single-parent family		Two-parent
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing
Clinton baseline	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
A) Clinical preventive services							
1) Tests	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%
2) Clinician visits under age 20	0.0%	0.0%	0.0%	0.0%	0.3%	0.4%	0.2%
B) Hearing aids for children	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%
C) Rehabilitation services extensions	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
D) Home health care and extended care facilities	0.6%	0.7%	0.6%	0.7%	0.6%	0.7%	0.6%
E) Enhanced mammograms							
1) Ages 50-64 annually	0.6%	0.6%	0.6%	0.6%	0.3%	0.3%	0.3%
2) Ages 40-49 biannually	0.3%	0.4%	0.3%	0.4%	0.2%	0.2%	0.2%
F) Enhanced pap smears	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%
G) Contraceptive drugs and prescription devices	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.0%
H) Extended care annual limit	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
I) Medical foods (PKU, etc.)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
J) Outpatient drugs--accessories and supplies	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
K) Outpatient speech pathology and audiology services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
L) Durable medical equipment--replacement	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
M) Vision care limitation to periodicity schedule	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

TABLE 1. Percentage Change in Premiums for Expanded Benefits, Under Four Types of Coverage

Benefit	Individual		Couple		Single-parent family		Two-parent family	
	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing	Low cost sharing	High cost sharing
N) Investigational treatments--discretion of plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
O) Extracontractual items and services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
P) Hospital deductible of $250--low cost sharing plan	-1.6%	0.0%	-1.6%	0.0%	-1.5%	0.0%	-1.5%	0.0%
Q) Drug copayment of $10--low cost sharing plan	-2.0%	0.0%	-2.0%	0.0%	-1.9%	0.0%	-1.9%	0.0%
R) Individual max. out-of-pocket increased from $1,500 to $2,500--high cost sharing plan	0.0%	-4.9%	0.0%	-4.9%	0.0%	-4.7%	0.0%	-4.7%
Insurance units--in thousands* (total = 107,076)	51,503		17,220		11,419		26,933	
Population--in thousands* (total = 223,621)	51,503		34,522		31,954		105,641	
Percentage children	0.0%		0.0%		60.6%		46.6%	

*Except those people who primarily rely on Medicare for their health insurance.

Source: Actuarial value of benefit variations calculated uses CRS Health Benefits Model v. 5.3. Demographic adjusters developed from data provided by major insurers, the Office of Personnel Management and the Nation Medical Expenditures Survey. Insurance units and population data developed using the Census Bureau's March 1993 Current Population Survey.

TABLE 2. Modifications to the Health Security Act

Benefit	Proposed Benefit Changes
A. Enhanced Children's Preventive Services 1. Tests 2. Clinician visits under age 20	Modifications to S. 1757 that either increase or decrease the incidence of clinical preventive services.
B. Hearing Aids and Comprehensive Hearing Assessments for Children under 18	Benefit added to S. 1757 for children who have failed a hearing screening as originally covered by S. 1757.
C. Rehabilitation Services Extensions	S. 1757 benefits clarified include coverage for outpatient respiratory therapy, and audiology services for outpatient speech-language pathology services. Established a maintenance or prevention program to include the following services: 1. Rehab health professional to provide initial evaluation & periodic oversight of the patient. 2. Rehab health professional to design a maintenance or prevention program appropriate for the patient. 3. Instruct patient and family members on how program is to be implemented. 4. Periodic reevaluations (in addition to a reevaluation at the end of each 60 day period). The plan will not deny coverage for outpatient occupational therapy, outpatient physical therapy, outpatient respiratory therapy and outpatient speech language pathology services and audiology services as a result of a disorder or other health condition. (S. 1757 only provides coverage if condition is a result of an illness or injury.
D. Home Health Care and Extended Care Facilities Extensions	Extends the coverage clause under S. 1757 to include conditions that did not result from an illness or injury. Also extends the annual number of visits in ECF if the care is found to be a "cost-effective alternative to necessary inpatient hospitalization".
E. Enhanced Mammograms	Augments the benefit under S. 1757 for: · Age 50-64 to cover mammograms annually rather than biannually. · For 40-49 to cover mammograms biannually.
F. Enhanced Pap Smears	Benefit added to S. 1757 to cover pap smears annually unless individual has 3 years of negative pap smears and no risk factors for STDs or cervical cancer.
G. Contraceptive Drugs and Prescription Devices	Extends benefit to include coverage for contraceptives drugs and prescription devices.
H. Extended care annual limit	Provides for an annual limit of 100 days for extended care services, with conditions under which the limit can be waived.

TABLE 2. Modifications to the Health Security Act

Benefit	Proposed Benefit Changes
I. Medical foods (PKU, etc.)	Medical foods prescribed by a physician are added to the outpatient prescription drugs and biologicals coverage.
J. Outpatient drugs accessories and supplies	Clarifies accessories and supplies typically covered under current health insurance policies. For example, syringes and glucose testing supplies for diabetics.
K. Outpatient speech pathology and audiology services	Under outpatient rehabilitation services, clarifies that outpatient speech language and audiology services are covered for the purpose of attaining or restoring speech.
L. Durable medical equipment–replacement	Clarifying language covering the replacement of durable medical equipment. Conforms with typical current insurance practices.
M. Vision care limitation to periodicity schedule	Allows the Board to establish the periodicity schedule for benefit.
N. Investigational treatments–discretion of plan	Allows the plan to cover an investigational treatment at it's discretion, as long as it's done based upon objective protocols and applied consistently.
O. Extracontractual items and services	Allows the plan discretion to use cost effective alternatives, as long as appropriate treatment is provided.
P. Hospital deductible of $250 - low cost sharing plan	Increase from $0 to $250
Q. Drug copayment of $10–low cost sharing plan	Increase copayment from $5 to $10
R. Individual maximum out-of-pocket increased from $1,500 to $2,500–high cost sharing plan	Increase individual maximum out-of-pocket liability from $1,500 to $2,500. Leave family liability at $3,000.

Modelling specs for MBB2

Benefit package/premiums	5% below CBO's HSA, plus adverse selection "tax" of: 1996-98 8% 1999 (year 4) 6% 2000 (year 5) 5% 2001 (year 6) 0%
Premium caps	same as HSA, in principle, but will be impossible to get same effectiveness without universal coverage, since more $ will be outside premiums for a while. Will supply percents and growth rates through time separately.
Before universal coverage (year 5), age rating	maximum ratio 2:1. Use AHCPR breaks devised for L&HR/Finance.
6 month pre-existing condition waiting period if previously uninsured, until universal coverage	reduces adverse selection, but insignificantly (ignore).
Uncompensated care pool for interim period	Financed through community rate, should have no net effect on premium vs. CBO's HSA if premium caps in place and net average provider prices can be assumed to adjust appropriately each year as well, EXCEPT for utilization increase due to claims-based reimbursement for high risk cases. Need to add x% to premium for this.
General Individual Mandate after 5 years (nonworkers, part-timers, self-employed)	Bulk of uninsured will get coverage in year 6.
Medicaid cash	capitated as in HSA from year 1 in all states
Medicaid non-cash	capitated until individual mandate, covered from year 1 in all states

Firms with 100+	employer mandate triggered if 85% of families in these firms who are currently uninsured are not covered after three years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 25-99	employer mandate triggered if 80% of families in these firms who are currently uninsured are not covered after four years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 1-24	employer mandate triggered if 75% of families in these firms who are currently uninsured are not covered after five years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firm subsidy schedule for firms that do offer:	2.8-12% individual wage caps, depending on firm size and average wage of firm;
Payroll assessments:	firms with $\leq$ 10 that don't offer pay 1% of payroll; firms with $\geq$ 11 that don't offer pay 2% of payroll. firms with $\geq$ 1000 pay ??? (hard to levy with no mandate)

Household subsidies:	HSA on 20% share; HSA schedule for non-full time workers for 80% share, counting wage and self-employed income; MAYBE: overlay 4-6% income protection for workers in exempt firms;

I. Financial highlights

- Premium higher during interim transition to universal coverage, because:
  - Medicaid larger percentage of community rating pool
  - adverse selection until mandates complete
- Number of premium subsidy recipients is smaller during interim transition to universal coverage, until mandates complete universal coverage.
- Medicaid savings phased-in quicker, but given higher premiums, may require higher payments per capita than in HSA.
- Number of uninsured determined by:

II. Risks

- Medicaid "in" before universal coverage may increase pressure for self-insurance to avoid higher community rate.
- May be impossible to sustain 1000+ assessment until year 4. Most financing packages need this money.
- Uninsured problems could increase during interim.

→ Keep in mind cost sharing subsidies

What if 20 → 25% and $2,500/3000 ? 7%
5000 ? Almost 8%

Hay Huggins → CRS

What if 20 → 25 and $250 and $[illegible] = 5%
or 2500/3000 " " " " = 5%

Prescription Drugs

	FFS	HMO
1% ↓ =	FFS = 40%	30%
	HMO = $[illegible]13	
2% ↓ =	FFS = 60%	40%
	HMO = $16	

Effect on Cost sharing

What if Δ HMO to coinsurance ?

e.g. 25% for lower, 30% higher

$5 = 20%
$10 = 40%

Dental

- What if put poor kids in Medicaid wrap for dental and drop dental for kids ?

Add 2%

HMO Δs

- try $75 or $50 1 day deductible
- try $250 per admission deductible

Which saves more?

Comparable savings w/ $60 1 day copay w/out limit on days
$75 1 day copay for $10 days

30% —

Take out services -

- dental, mental, preventive, extended care, home health, rehab, dme

Raise deductible -

$2,000-3,000

—

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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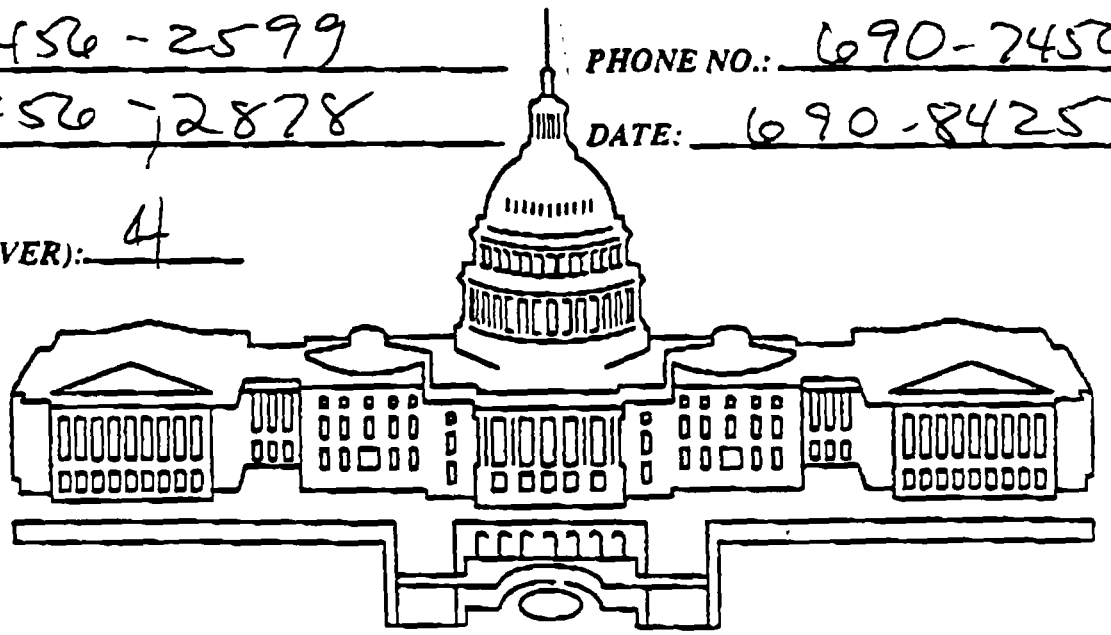

REMARKS:

This includes Lisa's additions.
Pls let me or Bridget know
if you want any changes — we'll
get it final + over to finance
Thanks!
K

DRAFT Talking Points - Guaranteed Benefits

Q. Why must there be a standardized benefits package?

* A standard benefit package prevents insurance companies from using benefit design to select good risks. For example, a package that fails to cover cancer would not be attractive to persons with that disease.

* Risk adjustment is more difficult without a standardized policy as it must rely on actuarial equivalence of benefits to compare risk.

* A standard benefit package permits people to evaluate health plan differences (such as price) comparing "apples to apples" without the confusing fine print that clarifies what the policy covers.

Q. Instead of Congress legislating a benefits package, why can't a Board determine one later (like Chafee)?

* For purposes of fiscal responsibility, as well as scoring, Congress must know the cost of the health reform plan they enact. The specifics of the benefits package is key to deriving premium estimates on which all other cost estimates are based.

* It also is incumbent upon Congress to know the cost of the health reform plan that individuals (like the Chafee bill) and/or employers are required to purchase.

* In addition, the health care provider and insurance industries will need to make projections for capital investments that require knowledge of what services will be called for under the reformed system.

* Politically, voters will insist on knowing what health reform promises in the way of coverage so they can evaluate this promise with their current coverage. They are not interested in a "pig in a poke."

Q. Why must the standard package be comprehensive? Why insist on a cadillac plan?

* Comprehensive does not mean cadillac. CBO has confirmed that the Health Security Act provides for average coverage. Its guaranteed benefits are equivalent to the <u>median</u> plan offered by large

companies.

* The distribution of existing plans is a tight one -- there is not that much difference from top to bottom. Most plans cover the services -- hospital, outpatient care, mental health, prescription drugs -- provided under the HSA. Unlike cadillac plans, the HSA does not include adult dental, private duty nursing, or first dollar coverage.

* What makes the HSA slightly (5%) above the median is its comprehensive coverage for prevention. Especially for pregnant women and children, such coverage is critically important.

Q. Why can't the standard package be a catastrophic plan?

* A catastrophic plan (one that covers health services after a large deductible, such as $1,000 or $2,000) effectively requires families to pay out of pocket for the entire cost of preventive and primary care services. This creates perverse financial incentives that will encourage people to delay care until preventable health problems become serious.

* For the poor and lower middle class, a catastrophic policy is the same as being uninsured.

* A bare bones-type policy leaves in place a significant amount of uncompensated care. The resulting cost shifting for that care will make it more difficult to control costs.

Q. Why can't there be two standard packages, including a comprehensive plan and a catastrophic plan, like in the Chafee bill?

* Adverse selection would be a serious problem. Healthy individuals would tend to choose the catastrophic coverage, waiting until they are sick to switch to the more comprehensive plan. If the sick are concentrated in the comprehensive plan its premium will rise, making it more unaffordable. This tiering of sick and healthy into different plans will exacerbate the premium difference, producing a spiral of more tiering and forcing the premium for comprehensive coverage up higher.

* This would also create a two-tiered system. The wealthy may be able to afford the good benefit package,

while the middle class and poor may be forced to purchase only catastrophic coverage with high out-of-pocket costs.

Q. What's wrong with a Nickles-like approach (catastrophic coverage plus a medisave account)?

* The presence of a medisave account would not eliminate the perverse financial incentives under a catastrophic plan that encourage people to avoid preventive and primary care. People would still need to choose between putting their extra dollar in a medisave account or using it for rent, etc.

* The poor and middle class are not likely to be able to create and maintain large (eg, $1000-2000 per person) savings accounts exclusively for health care.

* Employers are no more likely to voluntarily contribute toward medisave accounts than they are toward health plan premiums.

Q. Why can't the uninsured -- or all people -- simply join the FEHBP?

* In essence, the HSA provides all Americans with a FEHBP-like program for health insurance coverage and choice. However using the FEHBP, itself, for all Americans could be problematic for a few reasons:

* FEHBP does not now have a standard benefit package. As a result, there is a problem with adverse selection. People who anticipate being healthy tend to select the plans with less generous coverage (like the Mail Handlers plan) while people who are sick or anticipate upcoming health expenses tend to select more generous plans (like Blue Cross high option) at open season. This selection problem skews premium rates as health plans are priced according to the average health expenses of their own enrollees.

* FEHBP also is a nationally rated program -- at least for fee-for-service plans. Local health plans could have problems competing in such a system depending on how local health costs compare to national average costs. In high cost areas (like New York) local plans would be unable to compete against plans rated on average national health costs.

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fax transmittal

to:	Jennifer Klein
fax #:	456-2599
from:	Lisa Simpson, MB, BCh, MPH
date:	4/12/94
re:	technical and other fixes
pages:	4, including this cover sheet

NOTES:

COMPREHENSIVE BENEFIT PACKAGE

Page	Issue	Type of fix
35	**Hospital Services**: specifically exclude rehab. hospitals from definition of hospitals.	technical
36	**Health Professional Services**: on hold til further discussions / review of state issues (Lisa Rovin)	policy
38	**Ambulatory Medical and Surgical Services**: this language does not appear to cover what it was intended to - modifications required.	technical
94	**Clinical Preventive Services**:	
	• insert language to clarify that the NHB will determine a cost sharing schedule to apply to POS clinical preventive services and that cost sharing incurred from all POS services including preventive services does not contribute to the OOP maximum. To do this will also require specific language giving the NHB authority to change cost sharing for POS services.	policy
	• edit on page 94 - modify (b) to "consult with experts in clinical preventive services for children and adults".	technical
	• change provisions related to sexually transmitted diseases to allow for screening of males: i.e. add "annual screening for persons at risk of sexually transmitted diseases"	
	• add to page 40 for children under 3: "newborn screening for genetic and metabolic disorders" - cost estimate	policy/cost
63	• family planning inclusion - cost estimate	policy/cost

Extended care --

is "alternative to"

language OK.

↓

Must be an alternative

to covered services

Page	Issue	Type of Fix
	Mental Illness and Substance Abuse:	
338	• correct language to include "or a determination of not guilty by reason of insanity"	technical
92	• NHB language to be modified to allow authority to define visit differently	technical
	• on all pages where it appears change "criteria which the plan may choose to employ" to "based on reasonable standards of medical practice"	policy
57	• Sec. 1115(e)(2)(A): change "HEALTH PROFESSIONAL SERVICES" to "HEALTH PROFESSIONAL AND HEALTH FACILITY SERVICES" and on line 16, after 1112(c)(2) add: ", or when provided by a health facility that is legally authorized to provide the services in the state in which they are provided"	technical
59	• after "subclause (II)," insert "prior to January 1, 2001"	technical
82	• insert on lines 16 and 22 at start of paragraph: "prior to January 1, 2001, "	technical
87	• in cost sharing table, row on INR where low cost sharing has $25 per visit, insert "until January 1, 2001, and $10 per visit thereafter" and in column on higher cost sharing, insert "until January 1, 2001, and 20% thereafter"	technical
64	**Drugs:**	
	• formularies - language adequate, will incorporate specific intent to allow plans to use formularies in report language;	technical
	• medical foods - intend to cover very specific ones like PKU foods, but not Ensure (Lisa Simpson checking on scope and cost) - see attached proposed language;	policy/cost
	• Medical devices - bill silent - do we want to be explicit?	policy/cost
69	**Outpatient Rehabilitation Services**: see attached draft language	policy
70	**Durable Medical Equipment**: include Bobbie Silverstein language (attached); also ensure that report language/legislative history speaks to the fact that DME is intended to be used in either the home or office.	policy

	ISSUE	
71	**Dental**: change genetic to congenital	technical
74	**Investigational treatments**: see attached What about INDs?	policy/cost
	National Health Board: need to amend authority to give Board ability to modify cost sharing on POS services so that this cost sharing does not contribute to OOP maximum.	technical
80	**Exclusions**: hearing aids for kids - awaiting cost estimate from ARC, using BC/BS language	policy/cost
OTHER	Plan discretion re: individual benefit management and supplemental insurance exclusions; Uncovered/unattached children (foster, diversion, children of undocumented parents); Prior authorization issues for children (e.g. referral from an IEP, IFSP, child find program for evaluation).	

94 No cost sharing allowed for preventive services -- even if out-of-network?
Do out-of-network services apply to out-of-pocket maximum?

Providers -- limitations bec. of Medicare definitions?

Simpson/OASH
4/13/94
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MESSAGE: Here are some minor changes from Friday.

Medicaid EPSDT Benefits (for individuals under 21)	Covered by HSA (?)
1. Inpatient Hospital Services	Yes, §1111
2. Outpatient Hospital Services	Yes, §1111
3. Rural Health Clinic and Federally Qualified Health Centers Services	No. Services of clinic physicians would be covered. Services of certain professionals employed by center could be covered at plan discretion. However, the Act does not provide for coverage of any clinics other than emergency and ambulatory surgical services centers, §1112. FQHCs and RHCs would be essential providers but would not be paid for the health professional and health supportive services they furnish because these may not be a covered benefit.
4. Other Laboratory and X-ray Services	Yes, §1121
5. Skilled Nursing Facility Services	Only limited. HSA covers nursing facilities services but only if they are extended care services. §1119. Limitations of extended care services are (1) the services are covered only as an alternative as an inpatient following as an illness or injury and (2) the services covered only for 100 days/year (3) the services covered only if furnished by a rehabilitation facility or a skilled nursing facility. A child could under Medicaid receive services at nursing facility furnishing intermediate care up to a number of days a child needs, and without a prior hospitalization requirement and without regard to whether the conditions arises from an illness or a injury. This is an extremely important means for paying for special education placements in certain states.
6. Periodic Health Exams	Yes
7. Vision Exams and Eyeglasses	Yes but eyeglasses only for children under 18. §1125
8. Hearing Exams and Hearing Aids	Yes, hearing exams would be part of a preventive visit. §1114 or would be diagnostic service of a health professional. No on hearing aids.
9. Dental Exams and Complete Dental Care	Yes on preventive services.§1126 No on children over 18. Orthodontics not covered if child over age 12. Space maintainers not covered if child over 13. §1126
10. Immunizations	Yes
11. Health Education	No, its a discretionary service of the plan and includes only classes.§1127
12. Family Planning Services:	Yes, but contraceptive devices that are not prescribed are not covered. §1116

Medicaid EPSDT Benefits (for individuals under 21)	Covered by HSA (?)
13. Physician Services:	Yes
14. Medical or Remedial Care provided by licensed practitioners	No, if children are enrolled in a network-type plan, where the vast majority of Medicaid patients will be. The HSA covers services of health professionals if the service would be paid for if furnished by a physician. This would cover virtually all care. But the HSA permits network plans to select the professionals they will pay for covered services (except in the case of ECPs). There may be certain remedial services that are not services that physicians would furnish under state law. Moreover, the use of other professionals would be at the plan's optiopn. For example, a plan could refuse to pay a psychologist who furnishes counseling to a mentally ill child and require that the child receive all counseling from a psychiatrist. This would be a severe limitation on the availability of services in school settings or in underserved communities.
15. Home Health Services	Very limited. The Act covers home health services only if (1) they are an alternative to hospital treatment, (2) the care is needed for an illness or injury, (3) only if upon continuing evaluation it is determined that the child needs the service as an alternative to hospitalization. §1118. This means that a child who needs home health services for community functioning purposes but not as an alternative to hospitalization for an illness or injury would not be covered.
16. Private Duty Nursing Services	No, it is specifically excluded.§1141
17. Clinic Services	See above. Covered only if emergency care center or ambulatory surgery center. This means conceivably no reimbursement other than for the physician's time for both generally and special purpose public and private nonprofit clinics (family planning, local health department, Ryan White clinical services).
18. Physical Therapy	Very limited. Under the HSA, physical therapy is a form of outpatient rehabilitation service. §1123 The services covered only if needed for an illness or injury and only if functional ability can be restored. Therefore a child born with a gross motor developmental disability would not be covered under the HSA, nor would coverage be available for a child whose functional capacity could not be restored.
19. Occupational Therapy	See physical therapy.
20. Services with Individuals with Speech and Language Disorders	See physical therapy.
21. Prescribed Drugs	Yes.

Medicaid EPSDT Benefits (for individuals under 21)	Covered by HSA (?)
22. Dentures	Appears not to be included at all. §1141 excludes dentures except to the extent covered under §1126. §1126 does not provide for the coverage of dentures.
23. Prosthetic Devices	Only limited. Under §1124 prosthetic devices are only covered if they replace all or part of the function of an internal body organ. Under Medicaid, the prosthetic device can be prescribed to prevent or correct a physical deformity or malfunction, or to support a weak or deformed part of the body. Under the HSA, the device can be prescribed only to improve functioning or prevent deterioration. Under Medicaid, the potential uses are far broader than this. An example would be leg braces to prevent the development of a lower limb deformity. Under Medicaid, the braces can be prescribed on a prophylactic basis. Under the HSA, there would already have to be a condition requiring treatment.
24. Diagnostic, Screening, Preventive, and Rehabilitation Services	Only certain aspects of these benefits are covered. Screening, Diagnosis, and preventive services would be covered as noted above. But there are serious limitations on rehab services. In the case of inpatient rehab (§1119) the service is covered for only 100 days/year. In the case of outpatient rehab, the same limits applicable to speech and physical therapy apply. This seriously diminishes rehab services for children with developmental disabilities. Under Medicaid, these services would be paid for on a preventive basis.
25. Intermediate Care Facility Services (other than institutions for mental disease)	See discussion relating to skilled nursing facilities.
26. Inpatient Psychiatric Services	Very limited compared to Medicaid. Inpatient care is covered only for 30 days with a maximum 30 day extension. §1115. Many seriously mentally ill children in special education have their coverage paid for through the inpatient psychiatric program under Medicaid.
27. Nurse Midwife Services	At plan discretion. See health professional discussion.
28. Case management services	No. only at plan discretion for mentally ill persons. Otherwise, not a benefit package service. May be covered under Title III if funds are available. This service is commonly used to pay for the large amount of clinical social work and other supportive services for children in the child welfare system or in special education.
29. Emergency Hospital Services	Yes

Medicaid EPSDT Benefits (for individuals under 21)	Covered by HBA (?)
30. Home and Community - based Services	No. It would be a Title II service but only for severely disabled children.
31. Other Medical or Remedial care recognized under state law and specified by the secretary (skilled nursing for children under 21, Christian Science Sanitoria, Christian Science nurses, and transportation)	Except for limited extended care coverage discussed above, none of this is covered as a plan benefit.

1.EPSDT benefits include all items and services described in section 1905(a) plus any additional items and services described in 1905(r).